Board of Behavioral Sciences
1625 North Market Blvd., Suite S200, Sacramento, CA 95834
Telephone: (916) 574-7830 TTY: (800) 326-2297
www.bbs.ca.gov

LICENSED PROFESSIONAL CLINICAL COUNSELOR
IN-STATE EXPERIENCE VERIFICATION
OPTION 2 – PRE-EXISTING MULTIPLE CATEGORY METHOD

This form is to be completed by the applicant's California supervisor and submitted by the applicant with his or her *Application for Licensure and Examination*. All information on this form is subject to verification.

- Use this "Option 2" form for reporting hours under the PRE-EXISTING method (multiple categories)
- Use separate forms for each supervisor and each employment setting
- Ensure that the form is complete and correct prior to signing. Have the supervisor initial any changes.
- Do not submit your *Weekly Summary* forms unless specifically requested by the Board
- For your hours to qualify under "Option 2," your *Application for Licensure and Examination* MUST be postmarked by December 31, 2020.

APPLICANT NAME:

Last	First	Middle	Intern Number PCI

SUPERVISOR INFORMATION:

Dates of experience being claimed:	From: _____ mm/dd/yyyy	To: _____ mm/dd/yyyy	
Supervisor's Last Name	First	Middle	
Address: Number and Street			
City	State	Zip Code	Business Phone
License Type	License Number	State	Date First Licensed

- Physicians: Were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? ☐ N/A ☐ Yes: Date Board Certified: _____
  ☐ No Certification #: _____
- LPCCs: Did you meet the qualifications to treat couples and families during the entire period of supervision, as specified in California law? ☐ N/A ☐ Yes: Date you met the qualifications: _____
  ☐ No

APPLICANT'S EMPLOYER INFORMATION:

Name of Applicant's Employer			Business Phone	
Address Number and Street		City	State	Zip Code

Applicant: Last	First	Middle

1. Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy? ☐ Yes ☐ No
2. Was this experience gained in a private practice setting? ☐ Yes ☐ No
3. Was this experience gained in a hospital or community mental health setting? ☐ Yes ☐ No
4. Was this experience gained in a setting that provided oversight to ensure that the applicant's work meets the experience and supervision requirements and is within the scope of practice? ☐ Yes ☐ No
5. Was the applicant receiving pay? *If YES, attach a copy of the applicant's W-2 statement for each year experience is claimed. If a W-2 has not yet issued for this year, attach a copy of the current paystub. If applicant volunteered, submit a letter from the employer verifying volunteer status for these dates.* ☐ Yes ☐ No ☐ Volunteer

EXPERIENCE INFORMATION:

1. How many weeks of supervised experience are being claimed? _____ weeks		
2. Hours of Experience:		**Logged Hours**
a. Direct Counseling with Individuals, Groups, Couples or Families *(Minimum 1,750 hours)*		
• Of the hours recorded on line "a.", how many hours were gained while working with children, couples or families?		
b. Group Therapy or Counseling *(Maximum 500 hours)*		
c. Telehealth Counseling *(Maximum 375 hours)*		
Combined Maximum for # d, e, f and # 3 below is 1,250 hours:		
d. Administering and evaluating psychological tests of counselees, writing clinical reports and progress or process notes *(Maximum 250 hours)*		
e. Workshops, seminars, training sessions, or conferences directly related to professional clinical counseling *(Maximum 250 hours)*		
f. Client-Centered Advocacy		
3. Face-to-face supervision:	**Hours Per Week**	**Logged Hours**
a. Individual		
b. Group (group contained no more than **8** persons)		

NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation.

Signature of Supervisor: _____ Date: _____

ORIGINAL SIGNATURE REQUIRED